STATE OF MICHIGAN

DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS

OFFICE OF FINANCIAL AND INSURANCE REGULATION

Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX
Petitioner

v **File No. 121031-001**

UnitedHealthcare Insurance Company
Respondent

Issued and entered
this 27TH day of October 2011
by R. Kevin Clinton
Commissioner

ORDER

I. BACKGROUND

On April 29, 2011, XXXXX (Petitioner) filed a request for external review with the Commissioner of Financial and Insurance Regulation under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq*. The Petitioner receives health care benefits under a group plan that is underwritten by UnitedHealthcare Insurance Company (United).

The Commissioner notified United of the external review and requested the information used in making its adverse determination. On May 5, 2011, United furnished the requested information. After a preliminary review of the material submitted the Commissioner accepted the request for external review on May 6, 2011.

The issue here can be decided by applying the terms of the contract, United's *Choice Plus* certificate of coverage (the certificate). The Commissioner reviews contractual issues pursuant to MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

II. FACTUAL BACKGROUND

The Petitioner has been receiving breast cancer treatment since 2008 through the XXXXX at their hospital in XXXXX, Illinois.

In July 2010, Petitioner changed her insurance to United from BCBSM. In October 2010, the Petitioner had laboratory work and other medical services performed at XXXXX. In November, she received a bill for $10,775.00 for this care.

The Petitioner appealed the claims processing through United's internal grievance procedure. United affirmed its denial in a letter to Petitioner dated January 10, 2011.

III. ISSUE

Did United correctly process the claims for Petitioner's October 2010 medical care?

IV. ANALYSIS

Petitioner's Argument

The Petitioner presented her argument in a letter to United dated April 27, 2011:

> In July of 2010, we switched from Blue Cross/Blue Shield to your health care coverage. At that time I was in treatment for metastasized breast cancer at XXXXX Hospital in XXXXX, Illinois.
>
> * * *
>
> My agent, XXXXX, said when he sold me this policy, said there was a good chance that the treatment center in XXXXX would be "In Network" because United Health Care is a national policy. In the beginning of September 2010, I called my agent to confirm if the treatment center in XXXXX was "In Network." . . . He instructed me to call to verify. On September 15th, 2010, I called United Health Care and spoke with a lady by the name of XXXXX. I asked her about XXXXX and she told me that they were not in network. When I told her that the billing all came through XXXXX Hospital, she said they were in network. Since all of my bills read XXXXX Hospital, I took that as "In Network." Therefore on October 6th, 2010, I went and had a Pet Scan, a Zometa treatment, blood work and saw Dr. XXXXX. . . .
>
> I received a bill for over $10,775 in November of 2010. I called my agent who assured me that they too had received the same information when they called and that this was probably a mistake. Now since then it has been re-billed to the amount of $8,300. However, I would have had all of the tests done locally if I had been told that both the XXXXX and XXXXX Hospital were not in network. That's why I called 3 weeks ahead of time so that I could have scheduled these test[s] to be done in time for the appointment in October. . . .

Respondent's Argument

In a letter to the Petitioner dated March 25, 2011, United explained its January 10, 2011, denial of coverage:

> According to your Benefit Plan, section entitled Schedule of Benefits:
>
> > If specific Covered Health Services are not available from a Network provider, you may be eligible for Network Benefits when Covered Health Services are received from non-Network providers. In this situation, your Network Physician will notify us and, if we confirm that care is not available from a Network provider, we will work with you and your Network Physician to coordinate care through a non-Network provider.
>
> The Appeals Committee . . . reviewed a telephone record dated 9/15/2010 where you were advised by our Customer Care department that XXXXX in XXXXX, Illinois was not located by name. During the same call, our Customer Care department also advised that XXXXX was not currently participating under your plan. We found no record where you were advised that this service(s) would be covered as in-network if billed from this provider.
>
> We found no record on file that a network gap was requested with our Care Coordination Department. The notification on file states to pay the service(s) according to the provider's network status.

United maintains that its determination was in accordance with the provisions of the certificate.

Commissioner's Review

The explanation of benefits form issued by United on November 4, 2010, provides the details of how Petitioner's claims were processed:

SERVICE	AMOUNT CHARGED	PLAN PAYS	PATIENT PAYS
Misc.	6,148.97	2,152.14	3,996.83
Laboratory	3,398.00	1,189.30	2,208.70
Diagnostic	923.00	323.05	599.95
Radiology	6,108.00	2,137.80	3,970.20
TOTALS	$16,577.97	$5,802.29	$10,775.68

The form includes the following note:

> A non network health care provider or facility provided these services. Your claim has been paid based on your benefit plan, which provides reimbursement to non network health care providers or facilities at 50 percent of the provider's billed charges when no Medicare rate or other available rate source applies to the services. The member is responsible for the total amount indicated in the area of this statement showing what the patient owes. . . .

The Petitioner indicates that she relied upon a phone conversation with a United representative in which she was told that XXXXX was an in-network provider. United disputes this description of the information given to the Petitioner. Under PRIRA, the Commissioner's role is limited to determining whether a health plan has properly administered health care benefits under the terms of the applicable insurance contract. Resolution of the factual dispute described above cannot be part of a PRIRA decision because the PRIRA process lacks the hearing procedures necessary to make findings of fact based on evidence such as oral statements.

The Commissioner finds that United's payment for Petitioner's outpatient services was consistent with the terms of the certificate.

V. ORDER

The Commissioner upholds UnitedHealthcare Insurance Company's adverse determination of January 10, 2011. United is not responsible for additional payment for Petitioner's October 2010 services from XXXXX.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than 60 days from the date of this Order in the circuit court for the county where the covered person resides or in the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.